Assembly Bill No. 2667

Passed the Assembly August 31, 2006

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Chief Clerk of the Assembly

Passed the Senate August 31, 2006

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2006, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Section 22854 to the Government Code, to amend Section 1351 of, and to add Section 1351.3 to, the Health and Safety Code, to add Section 717.2 to the Insurance Code, and to add Article 2.99 (commencing with Section 14095) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

AB 2667, Baca. Health care providers and insurers: considerations.

The Public Employees' Medical and Hospital Care Act requires the Board of Administration of the Public Employees' Retirement System to approve health benefit plans for certain public employees and annuitants, and authorizes the board to contract with carriers offering health benefit plans.

This bill would authorize the board to consider specified factors with respect to any entity that seeks to contract with the system for the provision of health benefits.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law requires each application for licensure as a health care service plan or specialized health care service plan under these provisions to be accompanied by specified information.

This bill would require that each application, in addition, be accompanied by information relating to the applicant's history of providing, or arranging to provide for, certain health care services or benefits and the applicant's history of noncompliance with specified laws, regulations, and requirements.

This bill would require the department to consider any relevant information concerning misconduct with respect to any application for an initial license for any entity that seeks to contract with the system for the provision of health benefits.

Existing law provides for the licensure and regulation of health insurers by the Department of Insurance. Existing law prohibits any class of insurance business in the state without first being

admitted of that class by procuring a certificate of authority from the insurance Commissioner. The commissioner is required to issue a certificate of authority upon consideration of specified qualifications of the applicant.

This bill would require the commissioner to consider specified factors with respect to any application for a certificate of authority, or amended certificate of authority to transact health insurance.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law contains provisions governing the enrollment or reenrollment or contracting with entities for the provision of health care benefits under the Medi-Cal program of Medi-Cal providers. Medi-Cal services may also be obtained under specified types of contractual arrangements.

This bill would authorize the department to consider specified factors with regards to contracting with any entity for the provision of health care services under the Medi-Cal program.

The people of the State of California do enact as follows:

SECTION 1. Section 22854 is added to the Government Code, to read:

22854. (a) The board, in considering a contract with any entity that seeks to enter into a contract under this article for the provision of health care benefits or services, may consider all of the following:

(1) Whether the applicant is of reputable and responsible character. The board may consider any available information that the applicant has demonstrated a pattern and practice of violations of state or federal laws and regulations.

(2) Whether the applicant has the ability to provide, or arrange to provide for, health care benefits or services. The board may consider any of the following:

(A) Any prior history of providing, or arranging to provide for, health care services or benefits in this state, the applicant's history of substantial compliance with the requirements imposed

under that license, and applicable federal laws, regulations, and requirements.

(B) Any prior history in this state or any other state, of providing, or arranging to provide for, health care services or benefits authorized to receive Medicare Program reimbursement or Medicaid Program reimbursement, the applicant's history of substantial compliance with that state's requirements, and applicable federal laws, regulations, and requirements.

(C) Any prior history of providing, or arranging to provide for, health services as a licensed health professional or an individual or entity contracting with a health care service plan or insurer, and the applicant's history of substantial compliance with state requirements, and applicable federal law, regulations, and requirements.

(b) The board may also require the entity described in subdivision (a) to furnish other information or documents for the purposes of this section.

SEC. 2. Section 1351 of the Health and Safety Code is amended to read:

1351. Each application for licensure as a health care service plan or specialized health care service plan under this chapter shall be verified by an authorized representative of the applicant, and shall be in a form prescribed by the department. This application shall be accompanied by the fee prescribed by subdivision (a) of Section 1356 and shall set forth or be accompanied by each and all of the following:

(a) The basic organizational documents of the applicant; such as, the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments thereto.

(b) A copy of the bylaws, rules and regulations, or similar documents regulating the conduct of the internal affairs of the applicant.

(c) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, which shall include among others, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, each shareholder with over 5-percent interest in the case of a corporation, and all partners or members in the case of a

partnership or association, and each person who has loaned funds to the applicant for the operation of its business.

(d) A copy of any contract made, or to be made, between the applicant and any provider of health care services, or persons listed in subdivision (c), or any other person or organization agreeing to perform an administrative function or service for the plan. The director by rule may identify contracts excluded from this requirement and make provision for the submission of form contracts. The payment rendered or to be rendered to such provider of health care services shall be deemed confidential information that shall not be divulged by the director, except that such payment may be disclosed and become a public record in any legislative, administrative, or judicial proceeding or inquiry. The plan shall also submit the name and address of each physician employed by or contracting with the plan, together with his or her license number.

(e) A statement describing the plan, its method of providing for health care services and its physical facilities. If applicable, this statement shall include the health care delivery capabilities of the plan including the number of full-time and part-time primary physicians, the number of full-time and part-time and specialties of all nonprimary physicians; the numbers and types of licensed or state-certified health care support staff, the number of hospital beds contracted for, and the arrangements and the methods by which health care services will be provided. For purposes of this subdivision, primary physicians include general and family practitioners, internists, pediatricians, obstetricians, and gynecologists.

(f) A copy of the forms of evidence of coverage and of the disclosure forms or material which are to be issued to subscribers or enrollees of the plan.

(g) A copy of the form of the individual contract which is to be issued to individual subscribers and the form of group contract which is to be issued to any employers, unions, trustees, or other organizations.

(h) Financial statements accompanied by a report, certificate, or opinion of an independent certified public accountant. However, financial statements from public entities or political subdivisions of the state need not include a report, certificate, or opinion by an independent certified public accountant if the

financial statement complies with such requirements as may be established by regulation of the director.

(i) A description of the proposed method of marketing the plan and a copy of any contract made with any person to solicit on behalf of the plan or a copy of the form of agreement used and a list of the contracting parties.

(j) A power of attorney duly executed by any applicant, not domiciled in this state, appointing the director the true and lawful attorney in fact of such applicant in this state for the purposes of service of all lawful process in any legal action or proceeding against the plan on a cause of action arising in this state.

(k) A statement describing the service area or areas to be served, including the service location for each provider rendering professional services on behalf of the plan and the location of any other plan facilities where required by the director.

(*l*) A description of enrollee-subscriber grievance procedures to be utilized as required by this chapter, and a copy of the form specified by subdivision (c) of Section 1368.

(m) A description of the procedures and programs for internal review of the quality of health care pursuant to the requirements set forth in this chapter.

(n) A description of the mechanism by which enrollees and subscribers will be afforded an opportunity to express their views on matters relating to the policy and operation of the plan.

(o) Evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of the furnishing of health care services.

(p) Evidence of adequate insurance coverage or self-insurance to protect against losses of facilities where required by the director.

(q) If required by the director by rule pursuant to Section 1376, a fidelity bond or a surety bond in the amount prescribed.

(r) Evidence of adequate workmen’s compensation insurance coverage to protect against claims arising out of work-related injuries that might be brought by the employees and staff of a plan against the plan.

(s) All relevant information known to the applicant concerning whether the plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory

position in the plan, management company, or other affiliate, has any of the following:

(1) Any history of noncompliance with applicable state or federal laws, regulations, or requirements related to providing, or arranging to provide for, health care services or benefits in this state or any other state.

(2) Any history of noncompliance with applicable state or federal laws, regulations, or requirements related to providing, or arranging to provide for, health care services or benefits authorized for reimbursement under the federal Medicare or Medicaid Program.

(3) Any history of noncompliance with applicable state or federal laws, regulations, or requirements related to providing, or arranging for the provision of, health care services as a licensed health professional or an individual or entity contracting with a health care service plan or insurer in this state or any other state.

(t) Such other information as the director may reasonably require.

SEC. 3. Section 1351.3 is added to the Health and Safety Code, to read:

1351.3. On and after January 1, 2007, the department, in considering an application for an initial license for any entity under this chapter, shall consider any information provided concerning whether the plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company, or affiliate has any history of noncompliance, as described in subdivision (s) of Section 1351, and any other relevant information concerning misconduct.

SEC. 4. Section 717.2 is added to the Insurance Code, to read:

717.2. (a) On and after January 1, 2007, for purposes of Section 717, the commissioner shall consider, with respect to any application for a certificate of authority or amended certificate of authority to transact health insurance, as defined in subdivision (b) of Section 106, in this state, any available evidence regarding any one or more of the following:

(1) Any prior history of providing, or arranging to provide for, health care coverage, services, or benefits in this state and the

applicant's history of substantial compliance with applicable state and federal laws, regulations, and requirements.

(2) Any prior history in this state or any other state, of providing, or arranging to provide for, health care coverage, services, or benefits for which the applicant is authorized to receive Medicare Program reimbursement or Medicaid Program reimbursement, and the applicant's history of substantial compliance with applicable state and federal laws, regulations, and requirements.

(3) Any prior history on the part of the applicant's management of providing, or arranging to provide for, health services as a licensed health professional or an individual or entity contracting with a health care service plan or insurer, and the applicant's history of substantial compliance with state requirements, and applicable federal law, regulations, and requirements.

(b) The commissioner may also require the applicant to provide information or documents for the purposes of this section. The commissioner shall consider any other relevant information concerning misconduct.

SEC. 5. Article 2.99 (commencing with Section 14095) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 2.99. Provider Contract Considerations

14095. (a) For any entity or program that seeks to contract with the department to provide, or arrange for the provision of, managed health care services, disease management, or other health services contracted for on a basis other than fee-for-service, the department may consider, but shall not be limited to considering, all of the following:

(1) Whether the applicant is of reputable and responsible character. The department may consider any available information that the applicant has demonstrated a pattern and practice of violations of state or federal laws and regulations.

(2) Whether the applicant has the ability to provide, or arrange for the provision of, health care benefits or services. The department may consider evidence that may include all of the following:

(A) Any prior history of providing, or arranging for the provision of, health care services or benefits in this state, the applicant's history of substantial compliance with the requirements imposed under that license, and applicable federal laws, regulations, and requirements.

(B) Any prior history in this state or any other state, of providing, or arranging for the provision of, health care services or benefits authorized to receive Medicare Program reimbursement or Medicaid Program reimbursement, the applicant's history of substantial compliance with that state's requirements, and applicable federal laws, regulations, and requirements.

(C) Any prior history of providing, or arranging for the provision of, health services as a licensed health professional or an individual or entity contracting with a health care service plan or insurer, and the applicant's history of substantial compliance with state requirements, and applicable federal law, regulations, and requirements.

(b) The department may also require the entity described in subdivision (a) to furnish other information or documents for the proper administration and enforcement of the licensing laws.

(c) For purposes of paragraph (1) of subdivision (a), "applicant" shall include the applicant's management company, any affiliate of the applicant, and any controlling person, officer, director, or other person occupying a principal management or supervisory position for the applicant, its management company, or an affiliate of the applicant.

(d) Nothing in this section shall be construed to restrict or limit the department in any way from considering any other factor required by law, or determined by the department to be necessary for consideration, prior to entering into a contract for the provision of managed health care services.

Approved _____, 2006

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Governor